

T W E L V E C A S E S O F
P R A C T I C A L I N T E R E S T

W I T H C O M M E N T S , B E I N G

T H E S I S
F O R T H E D E G R E E
O F M . D . ,

B Y

E R N E S T E D W A R D P O R R I T T .

M . B . C . M . , F . R . C . S . E .



T H E S I S

By

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To every General Practitioner, confronted by the ordeal of writing a "Thesis" to complete his qualification for the highest order which he can receive from his Alma Mater, the problem of selecting the subject is either ludicrously easy or practically impossible. The easy solution is to select any subject, from A to Z. in the Medical Dictionary, to place the title on the top of a sheet of clean foolscap and having read more or less carefully the article written on the chosen theme in a Dictionary of Medicine, gleaned a few original remarks from Standard text-books, and searched the Index of the Medical Journals for illustrative cases, to rewrite other mens' conclusions, and add any case that may have come under his own knowledge. To this a final polish of carefully selected phrases, an interesting description of a post mortem or a more or less fictional list of startling recoveries under the latest medical treatment with a table of statistics, will complete an essay which may perhaps convince his examiner that the candidate has studied his subject, and is worthy of the Halo for which he strives.

The Difficult Way is that which presents itself to a medical man, who in the strenuous life of a Gener-

al Practitioner, finds no spare time for essay writing or who is perhaps too honest to insult his late Professors with a varnished mosaic of other mens brains.

To such a one the problem of a Thesis presents innumerable difficulties. His daily occupation is one tedious round of minor ailments, in which the most skilled diagnostician can detect nothing abnormal or interesting, and of which the doleful monotony acts as an increasing narcotic to a brain already physically tired.

As a Surgeon in Colonial practice, I have thought that a description of Twelve Cases of Practical Interest seen by myself and watched from their onset to their termination with simple comments of my own, may be as acceptable to my Professors as a practical proof of intelligence, as a well-written description culled from extraneous sources.

The majority of these cases have been under my observation in the wards of the Public Hospital in Wanganui. New Zealand. The others have occurred in my private practice. The notes I append are drawn from my personal note-book and from the official case-book of the Hospital.

It will be seen that in the simple comments append-

ed to each case I have refrained from adding references to any standard works or to the views of celebrated surgeons, believing that my unassisted expression of opinion, while it may be indicative of my ignorance, is yet the honest inference I have drawn from each case.

SIX CASES OF SURGICAL
INTEREST WITH COMMENTS.

CASE, 1.

A Case of Irreducible hernia of which the Sac
contained two fishbones.

CASE, 11.

Rupture of Bladder -- Laparotomy. -- Death.
37 hours after accident.

CASE, 111.

A Case of Ruptured Kidney. -- Removal. --
Recovery.

CASE, 1V.

Case of Rupture of Patellar Ligament and Tissues
exposing Knee Joint.

CASE, V.

Complete Destruction of Subcutaneous Tissue in
Thigh of Infant.

CASE, VI,

Case of Fulminating Appendicitis. -- Removal of
Gangrenous Appendix. -- Recovery.

SIX CASES OF MEDICAL
INTEREST.

CASE, VII.

A Case of Enteric Fever with Marked Cardiac
Symptoms in Prodromal Stage.

CASE, VIII.

A Case of Ulcerative Endocarditis.

CASE, IX.

A Case of destruction of Soft Palate following
acute Pharyngitis.

CASE, X.

A Case of Hydated disease of Pleura.

CASE, XI.

A Case of Fracture of Cervical Spine.-- Recovery.

CASE, XII.

A Case of Spinal Concussion ending in Mania.

C A S E, I.

A case of irreducible Hernia, of which the sac
contained two Fishbones.

G.M., Aged 43., was admitted for radical cure of an irreducible Right Scrotal hernia.

Previous History. Patient states that five years ago he was kicked in the Right Groin by a horse.

Next day he noticed a small swelling in his Inguinal region which gradually increased in size. His medical adviser informed him that he was ruptured, and he bought a truss which he has worn continuously since that date, until a week before admission to Hospital. The swelling has been slowly increasing in size, and cannot be reduced. He has therefore decided to undergo Operation for radical cure.

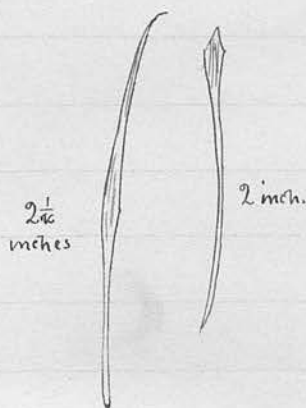
Examination. In the Right Inguinal canal and Right side of the Scrotum, is a hard elongated swelling, which does not return to the abdomen on taxis. There are no signs of strangulation, and only slight pain.

Operation. I made the usual incision and after dissecting through the tissues, I exposed a large thick-walled sac. I could not feel any Bowel in it, and accordingly cleared the sac from its lateral adhesions and opened it.

The sac was empty, and could be traced upwards to the

Internal ring, and downwards into the Scrotum, where it was firmly adherent.

In the cavity of the sac, I discovered two clean Fishbones, Two, and Two and a half inches in length respectively.



Fish Bones.

) The walls of the sac were enormous-
) mously thickened certainly a half
) inch in depth.
) The sac was evidently a patent
) Funicular process, and its walls
) were almost cartilaginous in hard-
) ness.

Judging that this was a case of Malignant infiltration, I removed as much as possible, but was obliged to leave a portion which was too firmly attached to the Testicle to admit of extirpation without serious interference with that organ. I feared that if my suspicions were correct, I might be obliged to perform castration at a later date. The Inguinal rings and canal were closed by McEwen's method.

The wound healed by first intention. The thickened portion left in the scrotum could be felt, but to my delight, diminished in hardness daily, and eventually vanished, thus proving that the densification of the tissue had been due to chronic irritation rather

than infiltration of malignant disease.

Comments on Case I.

From the previous history we can gauge the existence of the hernia for five years.

Now the chief interest of the case lies in the question, -- Whence came the fishbones? and I venture to suggest the following theory.

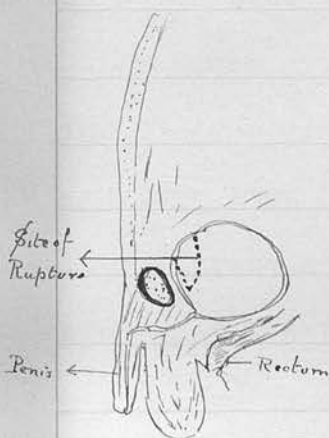
The bones ingested at some previous meal, have safely passed the cardiac and Pyloric orifices, and protected by a covering of mucus- (they were perfectly undigested when found)--are passing down the small intestine when the patient and host of the bones, is kicked on the inguinal region. Now, taking the anatomical significance of this locality. is it too difficult to believe that the sudden abdominal pressure, combined with the involuntary muscular efforts of the sufferer to escape from the horse's hoof, produces a hernial protusion.

In the loop of gut of which the hernia is formed, lie the foreign bodies. The force of the blow has driven their needle-like points into the soft mucous lining of the intestine, and following the usual procedure of sharp-pointed foreign bodies. they penetrate the thin intestinal wall aided by involuntary muscular

contraction and lie in the Hernial sac. Here Nature protests against further travelling, and the sac walls thicken and densify against the penetrative assault of the bones. The thickened sac grows until its size attracts the placid patient, who consults a doctor. All signs of irreducibility are present, none of strangulation. The operator finds no bowel. Perhaps after the escape of the bones, the relieved gut had returned to the abdominal cavity, and left to the hernial sac the task of entertaining the unwelcome guests. The thickened walls -- increasing under continual irritation -- simulates a true hernia, and it is left to the Surgeon to remove both Host and Guests.

Rupture of Bladder. -- Laparotomy. -- Death.

J.G., On May 1st., at 4 p.m., while standing on the brake of a truck, when shunting, received a severe blow on the back which forced him against the truck,



Sagittal Section.

Showing position of Rupture.

) and he was squeezed with tremen-
) dous force between the truck and
) an open gate. He fell to the
) ground in great pain. He was
) seen by a medical man at midnight
) who passed a Catheter and removed
) one pint of very bloody Urine.
) Patient was brought by special
) train to Hospital, arriving
) there 18 hours after the acci-
) dent. He stated that he emp-
) tied his bladder $\frac{3}{4}$ of an hour be-

fore accident.

On arrival he was collapsed, and had been bleed-
ing from penis.

There was great tenderness in Hypogastric
and Iliac regions -- Dulness in these areas and in
both flanks. Patient had a feeling that both legs
were useless, but sensation was perfect, and later he
drew both knees up. On admission four ounces of
bloody urine were removed by Catheter. Eight ounces

of fluid were injected into bladder and five ounces returned. During the afternoon, the patient became worse. His temperature and pulse rising and delirium occurring.

A constant desire to micturate was present, but no urine could be obtained by catheter. At 8 p.m., -- 32 hours after accident, Laparotomy was performed. The Bladder was found ruptured. on its anterior aspect and torn away from the Pubis, and a large quantity of bloody urine escaped from the wound. As the condition of the patient prevented any prolonged operation, a drainage tube was passed into the bladder through the rent, and the wound in the abdomen partially Sutured.

Patient died 7 a.m., 37 hours after accident.

Remarks.

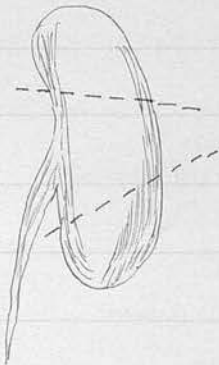
As soon as I was convinced of the nature of the lesion, and permitted by Hospital rules, I performed laparotomy, but the condition of the patient and the severity of the laceration, rendered any but a palliative operation impossible. The long railway journey and the exhaustion from shock, had reduced him to a state of Collapse, and I therefore felt it unjustified

ble to attempt to suture the rupture and prolong the operation.

It must appear to the critic that operation was unjustifiably delayed, but to this I plead in extenuation an Archaic rule of the Hospital which permits no operation until a concensus of opinion has been obtained from all the members of the staff -- and the delay thus caused undoubtedly militated against the small chance the patient might otherwise have had.

A Case of Ruptured Kidney. Removal. Recovery.

J.R., Aged 22, was engaged in loading gravel when a fall of earth occurred and he was forced violently against the cart, receiving a severe blow on the Right Lumbar region, and fracturing his left forearm.



Right Kidney

showing position
of rupture lines

) He was seen shortly after the
) accident by a doctor who adminis-
) tered Morphia, and passed a cath-
) eter drawing off several ounces
) of blood-stained Urine.
) On admission to the Hospital, the
) patient was cold and pale.
) Temperature 98, -- Pulse 160.
) Respiration 16. There was gener-
) -al abdominal tenderness and
) marked dulness in Right Lumbar
) region. The diagnosis of Rupture of Right Kidney was made,
) and the Kidney was exposed by
) the usual lumbar incision.

The Kidney was found ruptured into three pieces and lay embedded in a large clot. The organ was removed and all vessels and bleeding points ligatured. The wound packed with gauze after douching and the skin incision partly closed -- During the operation

patient collapsed completely and was apparently dead. After three hypodermic administrations of Strychine and Ether, two pints of Saline solution were transfused into the Median Basilic Vein and patient rallied slightly.

He was removed to bed, and two hours later another pint of Saline was transfused. The catheter drew off four ounces of bloody urine. Patient fluctuated for many days between Life and Death. Retention of Urine necessitated constant catheterisation, and it was not till the ninth day that blood disappeared from the urine.

He was discharged well on the 70th., day after the operation, and has continued so ever since, i.e., 2 years and 6 months.

Comments.

The great collapse from which the patient suffered immediately after the accident, was undoubtedly a blessing in a physiological disguise. The amount of Haemorrhage which had occurred was seen by the presence of the large clot in which the lacerated Kidney was found embedded, and there being no friends to give Alcohol, and thus increase the Haemorrhage, was a second advantage.

The interesting point was the apparent death of the patient during the operation, and only by repeated stimulation and transfusion was breathing restored.

The continuance of the blood in the urine for 9 days is an interesting sequel, for we may reasonably ask that if the source of haemorrhage is absolutely removed, whence was the blood derived I believe it probably came from the Ureter, which from its close attachment to the injured organ could hardly have escaped concomitant injury.

A Case of Rupture of Patella Ligament exposing
the Knee Joint.

W.W., A Maori aged 37, was admitted to the Wanganui Hospital with Compound Comminuted Fracture of the Right Thigh.

Previous History. Patient stated that six weeks ago while Pig hunting he received a bullet wound in the Right Thigh shattering the bone. He was carried to a Maori Whare where he lay for six weeks with Native attention and nursing, and finding that the indescribable dirt of his amateur nurses was not prejudicial to recovery he was conveyed Sixty miles by river to Hospital suffering greatly en route.

Examination. The Right femur is comminuted in the middle third. There is only one wound partly healed on the external Lateral Surface. From this a very Septic Sinus leads to the shattered shaft. The bullet has not been extracted, and cannot be localised as the Hospital does not possess a Röntgen Ray apparatus.

Operation. A long incision was made, the middle of which corresponded to the Sinus opening.

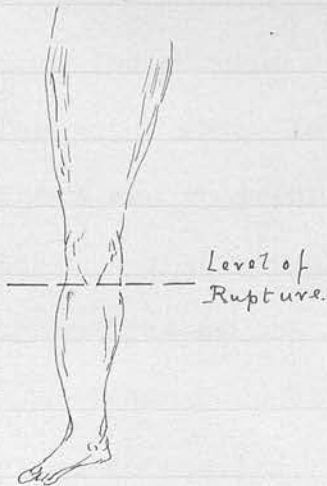
The Sinus was freely exposed and much loose bone was removed.

The Femur united slowly, and the wound healed well

-- The Patient's leg was only slightly shortened.

No bullet could be discovered. After a prolonged convalescence the splints being removed the knee was found immovable and during my absence from duty, a Colleague attempted to break down the New Adhesions to restore mobility.

We had been unable to perform passive movement during his convalescence as the extension weights had to be kept in position.



) On my return to duty in presence
) of my Colleague I attempted pas-
) sive movement and was assured by
) him that I was exerting no more
) force than he had previously
) employed.
) Without the slightest warning the
) knee suddenly flexed. -- The Pa-
) tella Ligament snapped complete-
) ly across and the Subpatellar
) tissues parted exactly as if a
) razor had been passed across
) them.

The knee joint lay before us completely exposed.

As may be supposed no antiseptic precautions had been taken in view of such an extraordinary accident

but I immediately Sutured the wound and it healed without Sepsis. The knee was fixed on a splint and I did not feel inclined to try any more passive movements.

Patient left Hospital, walking well and in good health but naturally with a stiff knee.

Comments on Case, 4.

The Case was interesting viewed as one of Compound Fracture. the only unsatisfactory point being that the patient still carries a bullet somewhere in his Anatomy.

The curious rupture of Skin, Tendon and Fascia is the point which interested me most unpleasantly. -- There was apparently no Muscular atrophy or degeneration, and as far as we could see by our involuntary inspection of the Joint Cavity no firm adhesions.

I can honestly vouch that no undue force was applied to the leg.-- Certainly none sufficient to rupture a powerful Ligament.

Had there been Atrophy from disuse surely it would have not affected a Ligament so powerful as the Patella without causing marked wasting of the adjacent muscles.

There was no indication of Malignant or Syphilitic infiltration that I could detect and I record this

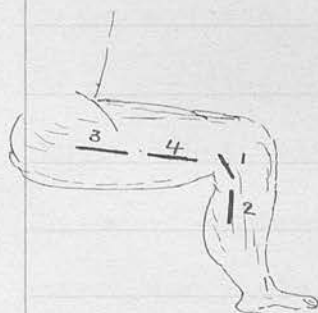
case as one which left the Practitioner in a state of
Conscience-Stricken Sorrowful conjecture.

Complete destruction of Subcutaneous tissue in

Thigh of an infant. Recovery.

Patient aged 30 days was bitten by a Mosquito or Horsefly, just above the Right Patella.

The child was restless all night and next morn-



Showing Lines of Incision

) ing the Thigh was swollen, hot,
) and tender. The knee was mova-
) ble, the leg normal in shape and
) colour. -- The whole of the
) Right Side of the abdomen was
) infiltrated and hard. No fluc-
) tuation was detected. The
) temperature at once assumed the
) hectic type and in 36 hours the
) child was to all appearances
) moribund.

) Even then no fluctuation could
) be detected, but after 20 min-
) utes immersion in a hot boracic

solution, the child seemed easier, and a few hours later a dark blue area appeared over the External Ligament of the knee. This was carefully incised and a quantity of pus evacuated. On cleaning the wound it was seen that the Joint Cavity was opened and synovial fluid escaped for 2 days, and then ceased completely.

The cavity of the Joint being evidently shut off by new adhesions. The child was greatly improved and took food eagerly for the first time for three days. --
 - Next day fluctuation appeared below the knee -- on the level of the Fibular head. An incision evacuated more pus. Twice afterwards incisions were made in the thigh on the external surface. From the two last incisions clotted pus, and long strands of dead cellular tissue were removed and gradually the skin of the Thigh wrinkled like that of an old orange. On introducing a finger through the skin incisions a large empty cavity could be explored, limited above by the Ligament of Poupart, below by the Ligaments of the knee, the whole of the Subcutaneous tissue of the Thigh having sloughed away.

Remarks.

I have described this case as one of interest to a General Practitioner, showing, how rapid absorption in the Infantile Lymphatics can be, how complete a destruction of cellular tissue may occur without corresponding destruction of muscles and bone, and how wonderful the resistance of Infantile Cartilage may be,
 (The knee joint was communicating for 3 days with a sloughing cavity and yet never showed any inflammatory

thickening or loss of mobility) and lastly that ultimate recovery in a young child should never be despaired of.

C A S E, VI.

A Case of Fulminating Appendicitis. Removal
of Gangrenous appendix. Recovery.

E.P., aged 32.

Previous History.

States that he was in

perfect health on the evening of May 29th., At breakfast the following morning he refused food, complaining of acute stomach-ache the first time in his life he had been so attacked and without any apparent cause. The Bowels moved but pain continuing in spite of hot fomentations a doctor was summoned in the afternoon. He diagnosed appendicitis, and gave a Hypodermic injection of Morphia. During the whole night the patient slept comfortably under the influence of Morphia.

At 11 a.m., on the following day Patient was seized with intense pain culminating in a very severe rigor followed by a rapid rise of temperature to 106°F. and immediate operation was decided upon.

The appendix was found to be gangrenous, and was removed.

Patient made a complete and rapid recovery.

Comment.

I have recorded this case as one of deep interest to the General Practitioner. -- The extraordinary violence of the pain which was not localised to the iliac

region, the fact that the patient has had no previous attacks, the rapid course of the disease and the complete recovery after Surgical interference are points to be considered.

Thirty-two hours elapsed between the first onset of pain in a healthy man, and the discovery of the gangrenous appendix. The pain was so excruciating that despite the exhibition of Morphia the patient could not control his cries.



Concussion

Appendix

) The Rigor was extremely severe
) and it is no exaggeration to say
) that the house shook with the
) violence of the "fit".

) N.B., The majority of houses in
) this Colony are of wood and in
) this town are built on sand.

) This may explain what may appear
) a Munchausen Statement.

) The prompt action of the Surgeon
) was rewarded by as prompt a re-

covery. I have never met with a case in which the disease, the Surgeon and the Relief were so remarkably swift in their onset.

(It may be of interest to my Examiners to know that the writer of this thesis was the patient referred

to in this case, the operator, DF Connolly, being one of my colleagues on the staff).

A Case of Typhoid with marked Cardiac Symptoms
in Prodromal Stage.

A.M., Aged 29.

Family History. -- Good.

Previous History.--- No previous illnesses.

I was summoned on February 9th., to see this case.

The temperature was 104.⁰ The pulse 120. The patient complained generally of great weakness. There was no complaint of Head or back-ache, and no diarrhoea or Iliac gurgling to be detected.

In examining the Heart I detected a faint blowing Mitral Murmur which gave me the impression of being of recent origin. On consultation with another Medical man, we again carefully examined the patient but could find no abnormal physical sign with the exception of the Cardiac bruit. She grew steadily worse and I sent her into the private hospital on February 13th., four days after my first visit. -- She complained of increasing weakness but the most careful examinations detected nothing beyond the cardiac symptoms previously noticed.

On February 18th., a few rose-coloured spots appeared on the abdomen. On the same evening slight gurgling was elicited by pressure in the Right Iliac

fossa, and coincidently the spleen was found slightly enlarged. The abdomen became tympanitic.

On the morning of the 19th., patient passed an extremely foul and bloody stool. From this date all the stools assumed this character and patient emaciated rapidly. No astringent or other medicine checked this continuous haemorrhage until, as a forlorn hope, I prescribed Supra-Renal extract -- grains five, every two hours.

The haemorrhage ceased abruptly and in order to avoid any chance of causing further bleeding I gave orders that the patient should not be moved (as we had been doing at regular intervals to avoid the formation of bed-sores) for Six hours. The Haemorrhage did not return but when the patient was moved on to her side Six hours later we found that the skin over the lower six Spinous processes and over both Posterior Superior Spines had sloughed.

After a tedious convalescence the patient completely recovered, and when discharged the most careful auscultation failed to detect any cardiac bruit.

I thought this case one of much interest to the General Practitioner, as a Diagnostic paradox.

At the onset, all the Symptoms pointed to the disease being of a Cardiac Nature, and not till some

anxious days had elapsed did the typical eruption set the question of diagnosis at rest.

The New Zealand practitioner is handicapped to an extent hardly credible to his more fortunate brethren at Home. as seen

In this case where I was unable to avail myself of Vidal's reaction.

The Cardiac bruit, I now believe to have been caused by changes in the Blood. The Intestinal haemorrhage was so profuse and so continuous that it resembled more the haemorrhage of a haemophilic patient than that of Intestinal Ulceration. The disappearance of the bruit during convalescence would be expected if my supposition is correct.

On discussing this case with one of my colleagues Dr Fenwick, he claimed the cardiac Symptom as a proof of a theory he has advanced in the Medical Journal, that the Intestinal Ulceration causes Sympathetic irritation of the Cardiac musculature. -- Lancet. August 11th., 1900.

Though cordially disagreeing with his theory of nerve irritation, I must admit that this case showed a close relationship existing between the changes in the Intestinal and Cardiac equilibrium.

TEMPERATURE CHART

MARCH

February

DAY	13	14	15	16	17	18	19	20	21	22	23	24	25	26	27	28	1	2	3	4	5	6	7	8	9	10	11	12
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M	105	100	99	100	100	110	120	116	125	139	133	130	130	130	128	128	130	136	120	130	106	128	134	145	138	130	138	112
Pulse	95	95	100	93	112	118	119	112	130	127	133	150	135	128	128	128	138	130	130	128	130	130	145	134	130	130	129	125
M	40	41	34	39	45	47	38	48	50	36	54	42	51	52	48	44	49	46	46	46	43	41	46	42	42	44	44	36
Res'n	41	44	42	52	51	55	40	48	48	45	49	50	58	48	48	47	47	44	44	44	43	41	42	44	32	49	40	38
Day of Disease																												
STOOLS	0	0	0	5	2	0	1	0	1	0	0	0	0	1	0	2	2	1	1	1	1	2	2	1	2	1	1	1

Blood

Blood

* Blood in Stool

Date:

21

April

[illegible]

A Case of Ulcerative Endocarditis.

A.B., A young lad of 18 was admitted with pains in back of Head and Neck.

Previous History. -- Always healthy.

Five days before admission he got chilled at work, and suffered from pain in the head. which got worse and spread down his neck,-- This pain continued till admission.

On admission. Temperature 103° . Respirations 34. Pulse 100.

No physical signs are found in Lungs except Slight crepitation at both bases.

A Mitral Systolic Murmur was detected on Examination of the Heart.

Urine. High-coloured, and contains Albumen.

Pupils. Equal, and react to light.

Patient became delirious shortly after admission, passing urine unconsciously. --

Next morning the pupils became dilated and unequal Muscular twitchings in both arms were noticed. Temperature, 103.8 . Pulse, 120. Respirations 48.

In the evening temperature rose to 106.6 . Pulse to 132. and Respirations to 60,-- and patient died at midnight.

Post Mortem Examination.

The Lungs are normal in appearance.

The Pericardium contained some ounces of Blood and purulent matter.

At the Base of the Heart posteriorly, there is some fibrinous exudation.

In the Wall of the Left Ventricle are several Small areas of purulent infiltration. There is an ulcerated patch on the Anterior Segment of the Mitral Valve, and another similar patch was seen on the Posterior Cusp. There is a small abscess on the Papillary Muscle the size of an oat seed.

Areas of Suppuration were found in the Liver, Kidneys and Brain.

I look upon this case as one of Acute Pyaemic infection leading to Ulcerative Endocarditis.

I think its interest lies in the sudden development and rapid course of the disease. No symptoms pointed to the Cardiac region except those obtained by auscultation, but all to some lesion in the brain.

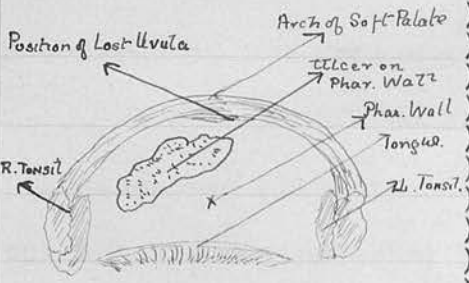
Comment.

The Symptoms all pointed to Some Cerebral lesion. There was a complete absence of any Cardiac Symptoms, and except for the Murmur obtained on auscultation

no attention would have been called to the Heart.

I must confess that my preliminary diagnosis was That
of Meningitis and only the patient's early decease
saved me from finally committing myself to a definite
statement of Brain Fever.

A Case of destruction of Soft Palate following
acute Pharyngitis.

<p>E.S. Aged 33.</p>  <p><u>Diagrammatic View of Palate & Pharynx.</u></p>	<p>) Came under my care suffer-) ing from sore throat and) Nasal discharge.) She has also a small abscess) half an inch below inner) canthus of Left Eye. --) and Suffers from Epiphora.</p>
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Previous History. Eighteen months ago, Patient nursed her brother, who was suffering from Cellulitis of the arm, from which he died. She contracted a Sore throat which became ulcerated and consulted a doctor, who touched the ulcer with caustic. The throat affection has become chronic and she consulted me for deafness and nasal discharge.

Examination. Patient is a thin, nervous woman.

The Soft Palate is a tightly stretched arch of about half an inch in depth. The Uvula has vanished. The Hard Palate shows Three white depressions in the mid-line, very suggestive of ulceration.

Posterior rhinoscopy is impossible as the Soft palate is glued to the pharyngeal wall.

There is a large nearly healed ulcer on the pharyngeal wall.

The Nasal Cavities are chronically inflamed and the mucous membrane is thickened. There is a free discharge of pus from both nostrils.

The opening of the Lachrymal duct is closed, and the secretion has collected and formed an abscess which has burst externally just below the inner Canthus of the Eye.

The Left Tympanum is perforated, only a thin margin of tympanic membrane remaining.

The Right Tympanum is intact, but purple in colour.

The Patient cannot hear a watch on either Side till it is placed against the Mastoid bone.

Patient was admitted to the Hospital but refused all Surgical treatment and was treated with repeated gargles and nasal douching.

She left, three weeks later. The discharge from nostrils had nearly ceased. Food could be swallowed without pain and hearing was much improved.

I have recorded this case as one which proves to what lengths a Simple Sore throat may spread. There was undoubted Septic infection and a resulting sore throat. This being neglected led to ulceration of

the palate and Nasopharynx, spreading to both Eustachian tubes and the Nasal Cavities.

My Colleague under whose care she was placed during her residence in The Hospital wished to drill into the Left Antrum believing that an Empyema existed. The patient energetically declined any operative interference and would not even permit the slitting of the Canaliculus or dilation of the Nasal duct.

A Case of Hydated disease of Pleura.

G.M., Aged 8 years, was admitted under my care suffering from supposed "Pthisis".

Previous History. Five months ago patient caught cold, followed by severe cough and pain in Right Side of chest. Ever since she has been weak and miserable and unable to attend school.

On Examination. The Right Side of the chest anteriorly and posteriorly is absolutely dull on percussion.

No breath sounds are detected.

Four days later I explored the chest with a hypodermic needle, and drew off clear fluid. I then introduced an aspirating needle, below the angle of the Scapula, and Thirteen and one half ounces of very clear fluid was removed. Patient stood the operation well, but coughed a good deal, She had whiskey before, and during operation.

Before the needle was withdrawn, the Right Side of the chest was lightly percussed and gave a resonant note all over.

When the needle was withdrawn, a little circle of Emphysema appeared round the puncture. A shred of Membrane was found adherent to the needle.

Patient continued to cough and complained of shortness of breath.

The Emphysema Spread all over the back, up the Right Side of the neck, and over the right side of the face, finally involving the whole face, neck, and body.

The Breathing became more difficult and patient was very restless. The Pulse remained good but suddenly the Respiration ceased, and patient died, exactly one hour after the needle was withdrawn.

The Fluid was examined.

Specific Gravity. 1015. No albumen.

Chlorides were present, but no Hooklets.

Microscopical examination of the piece of membrane showed it to be a portion of a cyst wall. No Post Mortem was allowed.

Comment.

As every precaution had been taken I am quite at a loss to explain the cause of the Emphysema. It was so sudden and progressed with such extra-ordinary rapidity, that nothing that I could do had any effect in retarding it.

The Fluid aspirated I believe was that of a Hydated Cyst. In this country Hydatid disease is so common that nearly every cyst of Lung or Liver proves to

be Hydated in Nature.

Thirteen and one half ounces would form the contents of a fair-sized cyst, quite sufficiently large to fill one side of a child's chest. There was certainly no communication with a Bronchus, or we should have had a definite History of expectorated matter containing daughter cyst.

I can only conclude that this was a case of Hydated disease of the Pleura in which the Lung had been greatly compressed by the growing cyst. On emptying the cyst, the Lung must have expanded, and coughing occurring in paroxysms, air must have been sucked into the aspiration wound and forced by some Valvular action into the tissues.

A Case of Fracture of Cervical Spine. Recovery
after two and a half years.

April 12th., 1900. A.C., Aged 42, was admitted suffering from almost complete motor paralysis.

Patient is a strong, healthy man, who states that the day before admission he was building a straw-stack. He slipped off it and fell on his head, his body doubling under him.

He did not lose consciousness, but felt stupid for some time.

He found that he was completely paralysed except in his head, and Right upper arm.

He was unable to micturate, but could speak and swallow all right.

On Admission. Patient has motor paralysis in both legs, body and Left arm.

He can move his Right upper arm. His head, throat and respiratory muscles are unaffected.

Sensation all over is perfect.

He complains that the slightest movement of his head gives him severe pain, which starts from the region of the sixth cervical Vertebra and radiates all through his body. The Sixth Cervical Spine is tender, but there is no bruising or evidence of displacement.

The Bladder was distended, and reached to the Umbilicus. -- thirty-four ounces of Urine were withdrawn, by Catheter.

The Temperature rose to 103° during the night, and patient perspired freely and slept well.

May 12th., Patient has been under observation for one month. His condition is unchanged.

July 12th., Patient is wasting. Paralysis continues. He has incontinence of Urine and Faeces, and the urine is alkaline.

September 1st., Voluntary motion is returning in the Right Arm and hand, and patient is putting on flesh rapidly.

He has still incontinence of Urine, and faeces.

There is frequent spasmodic contraction of the legs. The Bladder is washed out at intervals.

September 30th., The Right Arm is rapidly improving.

From this date, the patient entered on a tediously slow convalescence.

The incontinence ceased, and the muscular paralysis slowly diminished till when discharged on September 8th., 1902. Patient was apparently in good health with no trace of paralysis.

Comment.

This case is a striking example of the truth of the maxim that it is never too late to mend. and shows that in even an apparently hopeless case improvement may occur and eventual recovery ensue after a very lengthened period.

A Case of Spinal Concussion ending in Mania.

A.F., Aged 28. Was admitted in a delirious condition.

Her friends gave the following account.

Seven days ago, she was thrown from her horse, and fell on her head, and Right Shoulder. She was stunned and on recovering consciousness, talked incoherently.

On Admission. Patient is a healthy, well-built girl, who talks wildly and incoherently, sings at intervals, and occasionally bursts into laughter.

She can be controlled by firmness, and will move her arms, and draw up both legs when quietly ordered to do so.

Bladder functions Unimpaired.

Bowels Constipated.

Pupils moderately dilated, reacting to light. accomodation and consensually. Atropine produces enormous and long continued dilation. Knee jerks are exaggerated in both, but especially in the left knee.

Ankle Clonus is obtained on both sides but is most marked on Left side.

All skin reflexes are present.

There is a curious form of Tonic Spasm in the limbs. If the arm or leg is lifted into any position the muscles contract and hold it in this position, and it is not replaced without some force.

Two drops of Croton oil produced a motion.

Patient took food well. The exaggeration of the Knee jerks, and the Ankle Clonus disappeared within the next seven days. but the Mental condition grew worse, and finally patient became too violent for Hospital attendance and was removed to the Asylum.

Although I have seen numerous Cases of head injuries, I do not recall any case in which Mania occurred within fourteen days of the accident. There was apparently no Intracranial haemorrhage or Spinal injury that I could detect, but this patient rapidly passed from a hysterical and controllable stage of Mental excitement, to one of mental aberration accompanied by violence.
